Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name	**: MOHAMMAD ABDULKHALIQ M ABDEL MALEK**
Card No	**: I022-029-119902841-01**
Policy Holder	**: MOHAMMAD ABDULKHALIQ M ABDEL MALEK**
Payer Name	**: TAKAFUL EMARAT**
TPA	**: E CARE - Blue Network**
Validity	**: 02-10-2023** To **01-06-2024**
Gender	**: Male**
Date Of Birth	**: 15-Oct-1987**
Patient's Tel No	**: 0508987387**

Service Date **:30-Apr-2024** **Network** : Green

Health Provider **:Irham Medical Center Arjan** **Direct Access SP - YES**

Doctor's Name **:Humaira**

Co-Insurance :

CONSULTATION	LAB/RADIOLOGY	PHYSIO	PHARMACY	IP	MATERNITY	DENTAL
10% max	NIL	NIL	NIL LIMIT	NIL	10%	NA

Remarks :

☐ **Acute** ☐ **Pre-existing and chronic** ☐ **Maternity**

Chief Complaints : co allergic rash on the boby dark colour urine painful urination oe allergic rashes all over the body **Duration:**

Vitals: Temp : 36.9 Bp :124 Pulse :78 Resp :22

Clinical Findings:

Diagnosis: T78.40XS - Allergy, unspecified, sequela,N39.0 - Urinary tract infection, site not specified, **Date of Onset** :30/49/2024

Requested Investigations: 9, Consultation GP,81001, URNLS DIP STICK/TABLET REAGENT AUTO MICROSCOPY,101, GENARAL WELNES CHECKUP (55 TEST) **Estimated Cost** :

Prescriptions: 0195-123701-0391 - (CETIRIZINE HCL : 10 MG) FILM COATED TABLETS, **Estimated Cost** :

MEDICAL PRACTITIONER DECLARATION :

I declare that I am the patient's medical practitioner and that the particulars given are to the best of my knowledge true and correct.

PATIENT'S DECLARATION :

I hereby authorize any Healthcare provider, Insurer, Employer or other organization to release any information regarding my medical condition & history for purpose of determining insurance benefits.

Dr's Name : Humaira **Stamp :** 

Patient 's signature{Parent if minor} :  **Date :** 30-Apr-2024

Signature :  **Date** : 30-Apr-2024